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RESEARCH

Ampliando a rede: quando o usuário de drogas acessa a atenção psicossocial pela atenção básica

Expanding the network: when the drug user accesses psychosocial care through primary care services

Ampliando la red: cuando el usuario de drogas accesa la atención psicosocial por la atención básica

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ABSTRACT

Objective: this study aimed to revealing the specificities of drug users' access to Psychosocial Assistance through Primary Care health services. **Method:** the semi-structured interview technique with health professionals working in this scenario was used, and data analysis was performed through a critical and reflective perspective. **Results:** the focus of access of drug users has been guided, above all, in the logic of the host. It could be listed stress points that are established in the different modes of Primary Care approach to the reception of drug users, considering the proposals of Ethic Care through Reduction of Harm. **Conclusion:** it believes that health professionals involved should search for evidences in the proposals of the Public Health System and the Psychiatric Reform so these health networks qualify the answers they have provided to these individuals. **Descriptors:** Mental health, Illicit drugs, Patient care team.

RESUMO

Objetivo: desvelar as especificidades do acesso do usuário de drogas a Atenção Psicossocial pela Atenção Básica. **Método:** utiliza-se a técnica de entrevista semiestruturada junto aos profissionais de saúde que atuam neste cenário, realizando-se a análise dos dados através de uma perspectiva crítica e reflexiva. **Resultados:** o enfoque do acesso dos usuários de drogas tem se pautado, sobretudo, na lógica do acolhimento. Puderam-se elencar pontos de tensão que se estabelecem em diferentes modos de abordagem da Atenção Básica para o acolhimento dos usuários de drogas, considerando-se as propostas da Ética do Cuidado através da Redução de Danos. **Conclusão:** acredita-se que os profissionais de saúde envolvidos devam buscar pistas nas propostas do Sistema Único de Saúde e da Reforma Psiquiátrica para que as redes de saúde qualifiquem as respostas que têm oferecido a estes indivíduos. **Descritores:** Saúde mental, Drogas ilícitas, Equipe de assistência ao paciente.

RESUMEN

Objetivo: el presente estudio tuvo como objetivo desvelar las especificidades del acceso del usuario de drogas a la Atención Psicosocial por la Atención Básica. **Método:** se utilizó la técnica de entrevista semiestructurada junto a los profesionales de la salud que actúan en este sector, y se realizó el análisis de los datos a través de una perspectiva crítica y reflexiva. **Resultados:** el enfoque del acceso de los usuarios de drogas ha sido pautado, sobretudo, en la lógica de la acogida. Se puede enlazar los puntos de tensión que se establecen en los diferentes modos de enfoque de la Atención Básica para la acogida de los usuarios de drogas, considerándose las propuestas de la Ética del Cuidado através de la Reducción de Danos. **Conclusión:** Se cree que los profesionales de la salud envueltos deban buscar pistas en las propuestas del Sistema Único de Salud y en la Reforma Psiquiátrica para que las redes de salud cualifiquen las respuestas que les han ofrecido a estos individuos. **Descriptor:** Salud mental, Drogas ilícitas, Equipo de asistencia al paciente.

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INTRODUCTION

While the Ministry of Health policy stands in favor of building a model for attention to the user of alcohol and other drugs guided by the logic of harm reduction, the National Policy on Drugs admits and encourages the coexistence of different health care models to these users. The explanation for this work to reconcile divergent motivations regarding the content and the organization of health practices can be posted to conflict of interest between representatives of different social models in the country.¹

The focus of attention to drug users still have been based, often, on the legal, moral and public policy viewpoint, despite the approach with an expanded health perspective. This has called for the professionals, users and universities to fire debates that aim to face this dislocation.

The reality of primary care teams shows that, every day, they are faced with problems of “mental health”: 56% of family health teams confirmed performing “some action of mental health”. For its proximity to families and communities, primary care teams are a strategic resource for dealing with criticisms linked to the abuse of alcohol, drugs and various forms of psychological distress.²

Primary Care, especially the Family Health Strategy has an important role in the restructuring and reorganization of health services in the municipalities, because according to the Ministry of Health psychiatric complaints are the second leading cause for seeking treatment in primary care by population, the most common complaints to depression, anxiety, phobias and alcoholism.³

In this sense, the present study aimed to reveal the specifics of the drug user access to Psychosocial Attention for Primary Care. It justified by the need to advance the debate about this issue to confront the current crystallization of ways of knowing / doing in health services.

METHOD

The methodology used in this study was of a qualitative approach, using semi-structured interview technique. There were interviewed six health professionals working at the Mental Health Network of the city of Niteroi-RJ, which operate daily access to drug user. Data analysis was performed through a critical and reflective view.

It was submitted to the Ethics Committee of the University Hospital Antonio Pedro, and was accepted with Opinion nº 209.321.

RESULTS AND DISCUSSION

The Primary Care of Niteroi-RJ does not have the Family Health Program (FHP), but counts with the Family Medical Program (FMP).

Regarding the FMP that was inspiration for FHP, there is little production available to those who seek other references to the models working with the guideline of linking the clientele to care teams. Worth recording that FMP and FHP, though inspired in the same theoretical matrix of health monitoring, in the practice of the general practitioner and on the central guideline of the bond, are in its constitution and functioning, different.⁴

The city of Niteroi, traditional stronghold of Brazilian Municipality Movement, went to get the Cuban model, also in 1992, its reference to implementation of the family medicine model. The proposal of Niteroi, the Family Medical Program (FMP), ended up serving as a model for other health projects for the family, initially in the State of Rio de Janeiro, and later for various municipalities in other states. An important aspect of the organization of working case concerns the link guideline, ie the customer of ascription to a particular health team, which is responsible for the care to that population.⁴

As the name suggests, there is a limitation regarding the FMP with respect to FHP strengthening interdisciplinary. However, as the FHP, the FMP proposes to shelter, bond and accountability in relation to the user as markers of team work process.²

As the FMP is a territorial base program, it is a health service within the territory. They act as a gateway. It is the first place that the user of alcohol and other drugs, whether of their own free will, whether it be forwarded by family or detected by health professionals at the time of the consultation or general clinical issues. The FMP is a territorial base, is the health service within the territory. (E2)

The FMP in Niteroi counts with a Mental Health supervision after placing the host this user on his arrival. It highlights the importance of Mental Health Supervision, as there is weakness in the training of professionals Basic Attention to handle the demands of mental health.

These professionals working in Family Medical Program do this host and generate the supervision of mental health. (E2)

Thus, the supervision of a specialist in mental health enables comprehensive care to the enrolled population. This proposal is related to the notion of Matrix Support proposed by the Ministry of Health. The FHS incorporated the concepts of Matrix Support (MS) and reference staff, who are, at the same time, organizational arrangements and a methodology for management of health work, aiming to expand the possibilities for enhanced clinical dialogue and integration between different specialties and professions, such as the presence of mental health professional to work in collaboration with the Centers of Support for Family Health (NASF).⁵

In MS arrangement, the FHS share some cases with the mental health professional, with co-responsibility for the cases through joint discussions case, joint interventions with families and communities or assembly. This logic excludes the logic of routing; it aims to increase the response capacity of health problems for the local team.

When it comes to patients who arrive at basic health units with some mental health, users can be considered difficult to handle by health professionals who work there. This is when the health worker has to develop a way to deal with these people, whether or not with mental suffering. A little tolerance and a bit of firmness usually resolve these situations. What is not correct is to direct these people to the Mental Health merely as a way to move the issue forward.⁶

Sometimes, depending on the complexity of the case, the staff of FMP study setting sometimes ends up adhering to the routing logic.

(...) here, he agreeing the case, managing to get him to identify this as a problem, we forward him to the more specialized services, if needed. Matter, directly for supervision too. But, sometimes, goes directly to some services. (E?????????)

It is known that the drug use phenomenon requires, at times, a specialized care. However, when this happens, it is essential that the team of primary care which he had sought initially will not withdraw from the management of the case, but maintain a shared responsibility with the specialized service.

It is needed that the user enjoys a transversal host the entire line of care, and not a restricted host the screening or early arrival. The host needs to be considered a tool that incorporates human relations, suitable for all health professionals in all sectors, in each sequence of acts and modes that make up the work process, not limited to the act of receiving.⁷

Therefore, there are some conflicts between the primary care unit and specialized mental health centers, in order not occurring articulation and necessary interaction between the two systems, preventing fruitful technical meetings and difficulties in group work.⁸

Professional able to offer a good host is able to listen to the patient to a receptive, attentive and supportive way, being able to promote greater effectiveness and efficiency in the course of their work. For this, it is vital that the healthcare team of primary care has knowledge and motivation to act opposite to alcohol and drug users. For this to occur, the family health teams should be in constant training and dialogue with the mental health teams.⁹

The MFP has privileged opportunities to secure access to users who use/abuse of alcohol or other drugs to health services because they work in the territory and are more easily recognized services and accepted by the population than a Psychosocial Care Center for alcohol and drugs (CAPSAD) or other specialized mental health services.

The performance of FMP in the territory of logic presupposes detailed knowledge of the territory, not only as an area of coverage, but as a territory-process, because only then there is the opportunity to define problems, a set of priorities and resources to meet the health needs the community, considering the specific situation. The territory is understood as the space they live in social groups, their relationships and conditions of subsistence, employment, income, housing, access to education (and its known preexisting) as part of the environment, possessed of a culture, of conceptions about health and illness, family, society.⁴

Care in the logic of Primary Care can reduce the stigma of drug addiction and consolidate a care focused on Health Promotion.

Another specificity of access to psychosocial care via primary care is that many people seek the FHP (in this case, FMP) for an initially restricted demand to a physical complaint, but behind it there may be a use/abuse of psychoactive substances that cause such physical injuries. Thus, a health problem apparently only organic, can be a start for the healthcare professional initial access to the user and, from this, you can start a host that is also extended to the issue of drug addiction.

The literature points that are complaints/common findings drug user who can lead you to seek help initially in the offices of primary care: epigastric pain, nausea, vomiting, paresthesia, irritability, "depression", and anxiety, and insomnia, changes in blood pressure, sexual dysfunction, hemorrhage, falls, accidents, and aggression.¹⁰

To facilitate the detection of this problem, so that the team of primary care can improve access this user, it is important to pay attention also to the laboratory findings: Alcohol level in blood, gamma glutamyl transferase increased and corpuscular volume increased east. Concerning the more suggestive physical symptoms of alcohol and other drugs are: slight tremor, odor of alcohol, hepatomegaly, nasal irritation, irritation of the conjunctive, hypertension, blood pressure labile (suggestive of alcohol withdrawal

syndrome), symptoms gastrointestinal, tachycardia, "oral hygiene syndrome" (masking the odor of alcohol) and sexual dysfunction. And the everyday aspects are common findings: frequent absences at work and at school, history of trauma and frequent accidents, depression, anxiety and sleep disorders.¹⁰

Noteworthy is that the primary care team can make use of specific tools and standardized for the detection of high-risk drug use. They are: CAGE and AUDIT.

The CAGE questionnaire is a standard proposed by Ewing and Rouse in 1970. It consists of four questions referring to the perceived need to lower (C "Cut down") the intake of beverages; the hassle (The "Annoyed") because people criticize their drinking; guilt (G "Guilty") to drink, and the need to drink in the morning (and "Eye opener") to decrease nervousness, tremor or surf the wake. It must be answered yes or no to each question. The cutoff point is usually considered when answered two questions affirmatively, then the person being considered "probable alcoholic".¹¹

The AUDIT (The Alcohol Use Disorders Identification Test) was developed by an international group of researchers, under the auspices of the WHO (World Health Organization). Designed to be used in developed or developing countries, it is useful to identify the harmful and potentially dangerous if swallowed. It has good sensitivity and specificity being able to identify the dependency mild.¹²

It should evaluate the use of context: Last episode (withdrawal time), amount of substance used, route of administration, consumer environment and frequency of use. For this, you can also use a form.

But when the team chooses to use a questionnaire to optimize the detection of risk use, it is a *sine qua non* that the question of listening and bond are not left aside. Questionnaires are just a step, not the service itself. The staff of Primary Care has unique chances to build the relationship with users, which enhances the qualified access.

The link requires a "paradigm shift, therefore, to implement changes that result in a new work process, focusing on the subject, the trend is the rescue of the workspace as a place of subjects".¹³

Regarding the user of alcohol and other drugs, much is said, but landing is heard, resulting in deafening and immobilization of listening possibilities and decent reception. There is little preparedness to hear it, because they are invested with an imaginary referring their use practices to joy, irresponsibility, crime and affront to the habits and good customs. Meanwhile, often the uneasiness and suffering that this individual lives become invisible to the staff.¹⁴

Due to the heterogeneity that crosses the area of drugs, it has become increasingly necessary in view of interdisciplinarity, which allows, through the sharing of knowledge address the issue in its complexity without reductionism, because one cannot think about this topic inside a homogeneous conceptual field.¹⁴

You should be aware of this user from the perspective of extended clinic, trying to understand the user as well as to: family, financial and occupational situations, social network, leisure, housing conditions, as well as the significance of the use of psychoactive substances for their life.

Another way to approach that primary care can/should make use of it comes to the evaluation of the "motivational stage" of the individual to reduce substance use. The stage types for change are: pre-contemplation, Contemplation, Action and Maintenance.¹⁵

However, it is critical that the team make assessments and interventions without requiring abstinence. Today the proposal is that it can prioritize harm reduction, not an imposition of "be clean". The hegemony of prohibitionist political discourse about drugs did not prevent the emergence of an alternative political approach, counter-hegemonic, which was the frame of harm reduction as an alternative to reasoned public health care models exclusively about abstinence.¹

The "obsession" team for withdrawal by the user, the medicalization of what often is the order of "not medicalizable" has pointed to a set way that prevents the natural production in care relations. In the face of suffering that is not of the biological order, failures become biomedical approaches to diagnosis, the medicalization and total remission of symptoms. This notion, based on the biomedical paradigm, focuses on chemical aspects of the experiences with drugs and their interactions with the central nervous system, at the expense of considering the social and subjective meanings of the uses and effects of different substances. When looking at the relationship of different subjects with the same drug, note the possibilities and the diversity of experiences.

It is common to find teams, intending to help, began to consider that success in caring for these individuals is the pursuit of abstinence. One of the limitations pointed to the model of health care based solely on abstinence refers to the fact that this condition represents a major barrier to access by people who make harmful use or a dependent of drugs to health facilities. The high demand around the abstinence also implies reproaches and recriminations to episodes of relapse or recurrence drug use, making little cozy spaces health institutions those stigmatized as "weak", "bums", "shameless", "immoral".¹

Plus a superimplication, health services are not free of the ways of doing that reflect prejudice, consequence of the prohibitionist paradigm. The prohibition is linked to two explanatory models for the issue of drug use: the moral and criminal model.¹⁶ A disease model for the first, drug use sets up a moral problem, criminal act whose face is the incarceration of immoral / criminal. The disease model conceives drug use and addiction as a biologically determined pathology and, as such, should be approached with the offer of treatment and rehabilitation. Although the explanatory models differ as to their intervention proposals, they share the purpose of elimination of drug use - either by imprisonment or by the treatment. According to the perspective of non-tolerance to drugs, preventive actions specifically aimed at reducing the demand for drugs and treatment admits abstinence as the only plausible goal.¹

As a result of this, the moral and prohibitionist speech by the part of health professionals has produced barricades on user attempts to find access/reception in health facilities.

Since the principles of harm reduction are supported on pragmatism that drug use has always been and will always be present in human history.¹⁷

Thus the ideal of a drug-free society loses its meaning altogether. If the drug cannot be removed from society, it is possible to plan strategies to reduce the harm related to it, both for users and for the community. This approach has been advertised as one that gives

greater rationality to confront the issue of drugs, allowing, for example, understand the drug use as a public health problem and trafficking as a legal-police issue.¹

Fears that powered mistrust and resistance in relation to harm reduction strategies in the early years of its implementation have not been confirmed. The rampant consumption of illicit drugs and the escalation of the use of "soft" drugs to "hard" drugs, for example, are not phenomena observed in the countries and regions that have adopted the perspective of harm reduction. In contrast, there has been increased demand for treatment among users assisted by community harm reduction programs and increased access to health actions and services in general.¹⁸

The study participants mentioned about the meaning of harm reduction in their daily lives:

We work in line with harm reduction. And many times, even the person solving stop drug use, has a moment that she recognizes that it's not holding her wave as we speak in slang and she is losing control of its limit (...). Often, they can use the drug, work, and take care of the House, caring for children. (E5)

In this context, they mentioned the importance of the joint Primary Care with the Harm Reduction.

With harm reduction is a little different because that harm reduction is not a service. It is a program and its work is more in the same territory. So harm reduction will actively to the territory and has an encounter with these people. Will have situations where they will follow up with more proximity, will have situations where the user is going to bring the other. And usually, the damage reducers are residents of the territory. They already have knowledge and certain integration with people. This makes it easier for us to access it at first. These damage reducers will meet the patient. What happens is that they will not say 100%, but a large majority, no access to health services. Then, via a shared action with the FMP, harm reduction goes to the territory (E6).

Let me give an example: The patient, who was with me there, was totally intoxicated, but I think she could stand each eight (8) months smelling cornstarch. She wanted the act smell, but she did not want to risk going up the hill. She got into debt. Her to stop using cocaine, she began using cornstarch. She asked the doctor what he thought about that and he said, "I want you to make an inhalation with serum." It was a way to not get intoxicated by cornstarch, but he also did not say it was not for her to do. At least she was not at risk of death. She could pay all her bills. This person has no intention of stopping, she likes using drugs (...) Last year, she did not have to make any admission, administered the cornstarch it. But now comes at the end of the year, she lost her mother. It unsecured wave does not. It's the way she's getting to manage this suffering. "Doc did not drop the chip." To solve it... (E5)

The proposal of the Harm Reduction implies singular interventions that may involve the protected use, the reduction of drug use, the substitution of substances that cause less injuries or even abstinence. It is a public health strategy that seeks to minimize the adverse

consequences of consumption from a health point of view drugs and their social and economic aspects.¹⁷

Treatment guided by the logic of harm reduction is described as "low demand", by not requiring users abstinence as a mandatory prerequisite, which does not mean; however, that the focus of harm reduction. It opposes the abstinence as an ideal outcome to treatment. Instead of setting abstinence as the only acceptable goal of prevention and treatment, harm reduction combines the establishment of intermediate goals. The focus of this approach is the adoption of strategies to minimize the social and health harm related to drug use, even if the intervention does not produce an immediate decrease in consumption. Attention focuses on the social needs of the user's health, needs to be engaged in a respectful manner in delineating the goals for the treatment sought.^{1,19}

All this perspective brings out the imperative of care ethics, as it is for professional transcend the protocols in favor of life, in the empowerment of a care by the host.

CONCLUSION

It is considered that the psychosocial care in primary care is an important strategy to extend access to mental health to a greater number of users and reduce referrals of patients with less severe cases to specialist care.

For this, the mental health services in primary health care must conform to the model of care networks, territorial basis and transversal activities with other specific policies and seeking to build bridges and host.

Allow yourself to envision obstacles and advances, and revise assumptions that can effectively mark this historical and cultural process with contributions that make a difference and to assist in the clinical and social perspective that questions consensus and has space for the subject, not only for the use he makes of a substance.

In the struggle for citizenship, Harm Reduction creates conditions so that the subject will exercise caution to him and want a project, having an instituting clinic that seeks to minimize the notion of treatment as user duty.

From the host that produces a user-subject (not body-subjugated), seek to problematize practices of subjective vanishing, questioning the ideals of abstinence and ways of addressing the user that aggravate their suffering and increase their vulnerability.

In this sense, this proposal goes against the psychiatric reform, giving priority to the ethics of care, focused on psychosocial subject and citizenship aimed at the sustainability of its existence and redemption rights. It is considered here a refusal destruction of the subject

to a passivity that calls for welfare, or a subject-body (organic and biological) requesting drug solution, or even an ideal subject by means of abstinence.

Against this paradigm walks the proposal of qualification of these users access via primary care, a proposal which seeks to expand people's access to psychosocial care, in a timelier manner, the comprehensive health care. Considering that a large number of people with problems related to drugs are more accessible by health centers, this strategy becomes allied to the ethics of care, seeking the acceptance without restriction of physical spaces.

As opposed to the inflexibility of hard proposal for a drug-free society, flexibility is sought in agreement with all, respecting their demands and their time, recognizing the different relations of use, since there is an inclination to listen who remains involved with drugs, proposing a dialogue with other instances.

To advance this issue, it is believed that those involved should seek clues in the proposals of the Unified Health System and the Psychiatric Reform for the health networks qualify the answers we have been able to give these users.

The social impact of this and other studies in this line is the possibility to raise the debate on the proposal of care under the logic of acceptance without restriction of physical space, the Care Ethics for harm reduction, building a plan care based on the subject, not the substance of what he does use. With this, we recommend the development of studies that illuminate these aspects of care, with a view to contributing to the field of psychosocial care.

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